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ABSTRACT

This document contains the speeches presented at the Arizona health occupations conference held at Carefree in June 1972. Principal emphasis was on the need for cooperative planning for health occupations education, particularly in view of the trend to move preparatory programs administratively from health service institutions to the public education system. The speeches discuss various aspects of health manpower preparation needs and the cooperative roles of educational institutions, health professions associations, licensing boards, and health services facilities. The appendixes contain group session issues and recommendations, conference evaluation with comments from participants, and the conference invitation list. (MF)

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PEOPLE POWER FOR HEALTH SERVICES

CAREFREE INN

CAREFREE, ARIZONA

JUNE 1 & 2, 1972

CONFERENCE PROCEEDINGS

Sponsored By:

State Department of Education, Division of Vocational Education
College of Education, University of Arizona

In Cooperation With:

Arizona Regional Medical Program
Arizona Health Planning Authority
Arizona Hospital Association

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PURPOSE

Education for the millions who are part of our nation's health delivery systems has been undergoing significant change in the past several decades. Both the employers and people seeking health careers look increasingly to the educational systems for Health Occupations Education. Schools are more and more being expected to help assure a continuous supply of qualified health workers. As the educational systems begin to prepare health personnel, education's relationship with the health industry will require continuing analysis and restructuring to achieve the coordination and cooperation that is essential. Thus, the public education system can more effectively fulfill its obligation to youth and adults seeking career education and at the same time, help to meet the health manpower needs of the nation.

OBJECTIVES

Gain new insights into and better understanding of the collaborative roles of education and the health industry.

Examine and develop techniques for strengthening cooperation between education and the health industry.

Develop recommendations concerning cooperative planning for future health manpower services.

Dr. Weldon P. Shofstall: Opening Remarks

I'm very proud to bring you greetings as a representative of the State Department of Education, and to know that we are allowed to participate in this very important conference. It's a great pleasure for me to extend to you a real warm welcome, and I think there's no doubt in the minds of anybody in this room that you have many problems to consider. As I glance at your agenda, the range is there, without any doubt. You have a difficult task, and a great responsibility.

With the rising capacity of medicine to provide an array of services, the anticipated lowering of financial barriers for such services, and the growing acceptance of the public responsibility to be sure that all people have adequate health care, needs and demands for health care services continue to outstrip their availability. Today we find, and this is not news for anybody in this room, that qualified manpower is the critical factor in the provision of health services. If it were possible to envision ideal health services and their staffing for a community, a state, a nation; if it were possible for us to do that today, the continuing development of new knowledge and techniques, new patterns of services, and new methods of payment, would be constantly changing the needs, both for numbers and varieties of workers in the health service field. In the past, and to a great extent at present, the health professions and health facilities developed and guided the preparation and utilization of personnel within the framework of the state's and the health associations' rules, regulations, and policies. And my next statement is not a snide remark, it's a statement of fact - thus, we can give the health profession the credit for the status of health services today.

With the trend to move preparatory programs administratively from health service institutions to publicly supported educational institutions, there has been confusion, to say the least, and a lack of clarity about the roles and relationships of all the

groups concerned with health manpower. We're in a period of flux and change in the field of health services manpower. Educators must plan educational programs to provide a secure general base on which career development and mobility is possible, with a minimum of wasted time and effort. No educational system can supply the relevant level of skills and competence required without receiving active feedback and support from persons associated with the health industry and with the related occupations. The lack, as I see it, of active feedback, is a built-in weakness of a socialized, as compared with a private, health services delivery system.

The meetings scheduled for today and tomorrow are an attempt to begin such joint planning. I hope you'll find here the opportunity to explore the manpower issues pertinent to the provision of adequate health services and to develop recommendations for cooperative planning that will meet future manpower needs.

Before closing, this was intended to be a greeting, but having been in the teaching profession for 50 years, I can't pass up an opportunity; before closing, there are two aspects of the problem to which I direct your attention particularly. And, since I'm not a specialist in this field, let me turn to Dr. Robert Kinsinger, Program Director for the Kellogg Foundation, for delineation of these two areas for your consideration. First, and I'd like to quote, "It's generally recognized that a most promising concept in curriculum reform in the allied health field is frequently referred to as 'The Career Ladder'". I hope that is a familiar term to everybody in this room. Much study and discussion has been centered around the ways in which it may be possible to arrange for individuals seeking a career in the health field, to build consecutively each series of educational experiences upon his immediate preceding education without penalty for having joined the labor force during an interim period. A student shifting periodically over many years between the status of health worker and student should have a number of levels of entry into the health field available to him as he acquires an

appropriate fund of knowledge and a set of skills to function at each succeeding entry level. He should be able, with equal ease, to take up his studies where he left off, in order to prepare for the next level of his career.

This seemingly simple plan has not been broadly implemented for many reasons, but chiefly, due to the rigidity growing out of vested interests of the health specialist groups, schools, and colleges, and general resistance to change that reflects all human arrangements. The development of the career ladder concept, and this may shock some of you, but it may not - the development of the career ladder concept in the health manpower field must begin in the elementary school. I hope you don't forget this in your deliberations.

Dr. Kinsinger presents my second point as follows. Now, you may not be pointing your attention in this direction today at least, but I believe you'll have to eventually. "It's discouraging to observe students still being led through the lecture, reading assignment, class discussion, examination syndrome in this day of continuous loop single concept films, computer assisted instruction, sophisticated simulation devices, instant video tape replays, dial access learning centers, and programmed instruction." Industry has long ago learned that its survival depends upon constant utilization of new technological developments to increase productivity. Too many teachers either do not believe that technology has the same relevance for education, or they lack the ability or initiative to adapt developments in educational technology to their particular instructional responsibility.

Continuing Dr. Kinsinger, "Teaching as a teacher himself was taught is comfortable and can be considered a sure thing. It has worked for centuries, and is therefore safe and proven. This kind of thinking ignores the fact that we've developed techniques and devices that frequently make it possible for the student to teach himself something even more effectively than possible in the traditional classroom setting. The teacher is our most limited educational resource. He should never be used

to do something that can be done better or even as well in some other way. Rote teaching and repetitive drill is particularly unnecessary use of an instructor's time. A teacher can capture an explanation or demonstration on film or video tape to be made available as often as necessary to students without involving additional time of the instructor, and paced to the individual student's learning speed. Laboratory experiments do not have to be set up over and over again. We can bring the best minds in the world to our students for little more than the price of a long-distance telephone call through the use of tele-lectures. Improved simulators are rapidly freeing educators from total dependence on the clinical setting for some types of learning experiences. Through the miracle of closed-circuit television, as many dental hygiene students as the instructor wishes can have a chairside seat simultaneously and a magnified view of an inter-aural procedure superior to the instructor's view."

And, in closing, the people of the United States have set their priorities. They've asked for more and better health care, and have appropriated money to pay for it. To respond adequately, we must inaugurate fundamental changes in the largely uncoordinated efforts which presently characterize health occupations education. And, in turn, develop an articulated and effective system. This means kindergarten through graduate school. For too long, we seem to have assumed that the health services manpower problems could be solved by the university alone. I hope you have a challenging and successful meeting.

Dr. David W. Smith: Opening Remarks

On behalf of the College of Education and the University of Arizona, it is a distinct pleasure to welcome you to this most timely conference. I, along with you, am hopeful that out of the deliberations of the next one and a half days will come some of the critical pieces to the puzzle we have faced in this country since we have emerged as a dynamic, industrial, urban nation--namely, the development of a health care system that will bring feelings of dignity and worth to millions of Americans.

From my long years of experience in the field of rehabilitation and social welfare, wherein I have worked primarily with those who have received little or no health care throughout the course of their lifetimes, I can tell you that the feelings of worthlessness and depression often found in these people have been due to the fact that they have received no continuity in health care and that they simply do not feel well.

The Carnegie Commission on Higher Education, in a recent publication on Higher Education and the Nation's Health, describes present health care delivery as a "nonsystem" and describes the nation's goal as one of shifting to a "system" of health care delivery. The report further suggests that:

> "The nation's goal should be adequate and effective health care for the entire population, regardless of income. Many of the recommendations that will be made in this report--for example, the provision of nine new university health science centers, the development of about 126 area health education centers, and provision for a national health service corps--should help to overcome the present maldistribution of health manpower. Physicians, dentists, and allied health workers are likely to be attracted to areas where there are well-developed area health education centers. Our proposal, which calls for a broad geographic distribution of such facilities, should go far

> toward achieving more equitable geographic distribution of health manpower. Health personnel may be more willing to practice in remote, rural areas if there is a health education center within a reasonable distance. However, the full effect of such centers in attracting health manpower will doubtless not be experienced until a national health insurance system, perhaps with built-in features to provide special financial and nonfinancial incentives to health personnel for locating in remote areas, becomes a reality. A national health service corps could also play a key role in bringing health personnel to areas now poorly served."

This workshop recognizes the fact that in order for America to have a health care system (and I am in full agreement with the Carnegie report that we have none today) we must develop large pools of manpower in the health professions so that we can hopefully develop a health care system that is based on what I, along with many others, term the "well model" as opposed to what we now have--the "sick model"--in health care. An integral part of the strength of a nation has long been recognized to be education. I would like to add to that the factor of health and make the assumption that a healthy, well educated nation may not need to spend billions of dollars on intercontinental ballistics missiles and billions on wars that historically have had little, if any, positive effect on the course of this nation's history.

It has been indicated that a total health care system for Americans could cost upward of $80 billion. In terms of a gross national product that exceeds one trillion dollars, I believe this would be a very worthwhile expenditure and little more than we spend on national defense. The situation in health care is such that it may even rank below the level of the social welfare system which Congress, as it struggles with H.R.1, has found to be patched to a point where it can no longer be patched. In health care, I am afraid, we have not even something to be patched, which may be good.

The Carnegie report likens an adequate health care system to a public utility, and under point 4 of the chapter "The Future of Health Care Delivery," the Commission report states:

> "Gradually we are likely to shift toward a situation in which health care is a public utility. The government's role in protecting the health of the population will inevitably become broader in scope. In an era of increasing concern for the environment, greater attention will be paid to preventive epidemiology, population problems, control of water and air pollution, environmental sound levels, and related problems. As the trend toward a more comprehensive national health insurance system continues, the federal government will become increasingly concerned with adequacy and efficiency in the delivery of health care, with terms and methods of payment, and with the education and utilization of health manpower."

Thus, I would hope that your deliberations, according to the program, will deal with such mysteries as cooperative planning, a total health care plan for Arizona, the role of the legislature, education, and a look into the future concerning manpower needs (and here I must pause because what I am suggesting is that we cannot look into the future until we begin to examine the current situation). Hopefully this will be the beginning of many such conferences that will take up such topics as the elimination of duplication of effort, more appropriate use of manpower, the elimination of waste, and finally, but most important, the development of a health care system that will bring dignity and feelings of worth to all Americans.

Much of what is involved in finding solutions to the problem of developing a sound health care system may have to emerge from change and from the new. Eric Hoffer, the illustrious San Francisco longshoreman-turned philosopher, in his book, "The Ordeal of Change," has said:

> "It is my impression that no one really likes the new. We are afraid of it. It is not only as Dostoevsky put it that 'taking a new step, uttering a new word is what people fear most.' Even in slight things, the experience of the new is rarely without some stirring of foreboding."

SPEECHES

Dr. John F. Prince:

COOPERATIVE PLANNING FOR HEALTH MANPOWER--
MYTH OR REALITY

I'd like to take certain liberties at this time with our genial host at this beautiful Carefree hostelry. As I drove out here this morning, I was impressed with the happiness and joy that prevails on every road sign. I passed Sunshine Road, Rocking Chair Lane, Mocking Bird Hill, and then I came to Carefree Inn, and I had the feeling that for us, embarked upon a very sharp and burdensome task during the next day and a half, Carefree Inn is really not the proper title. So, I'm going to ask that we refer to this as "Care-Ridden Inn."

Secondly, to bring anything about medical service into the term of "carefree" is just nonsensical, of course. Medical service is not carefree. So, I know that in the next day and half we're going to launch ourselves into a study of many problems; we will analyze what we are doing about developing health service in the sense of manpower development. We're going to identify the gaps; we will come up with some good solutions; and I would hope there would come out of this a cooperative planning system--the whole State of Arizona needs to involve itself in this. And, then, at the end of our tour, we can once again refer to this as Carefree Inn, because we may have solved worlds, we should be tied together in some kind of a planning loop that will bring us, from time to time, together again to work for the future of Allied Health Training.

My topic is "Cooperative Planning for Health Manpower--Myth or Reality." We certainly have interest in cooperative planning nowadays. Many laymen are involving themselves for the first time in an arena, thinking and debating on health topics. The National Conference for Health Occupations

Education, held in New Orleans in 1970, had the purpose of assembling leaders in health and related fields, such as governmental and educational agencies. The Council explored ways to develop and improve relationships, thus binding together in cooperation colleges, proprietary institutions, hospitals, state agencies, and county agencies. And, the second purpose was to enhance coordination and planning in response to the growing need for health services and workers. Such may well be the purposes we have today.

There are here today many problem-solvers from many areas of our economy to face up to these health service problems.

Some of the questions I'd like to raise: Are we determining what needs to be done in the way of training in this state to meet the escalating needs? Are we really training? Are we reviewing whether cooperative planning is actually being done, and if it is being done, is it accomplishing anything?

Some people here are called the consumers in this new dialogue. We have long accepted health delivery service--it brought our kids into the world, it opened up our bellies and took out our appendix, it swabbed our throats, it immunized us to keep out unfriendly germs, and we paid the bill, which seemed reasonable enough for the services rendered.

But now, we are beginning to ask questions. For heaven's sake, why does it cost so much? Who can afford to be sick any more? Why do we talk about going to the doctor only when we get sick? Why don't we talk about maintenance of health? Are we really training people properly when we say, "go take an examination once a year"? Or, should they be going on a monthly basis to follow a systematic prevention system?

It's well, I think, to relate some of this change in our attitude toward the health delivery service to the history of this country. We, the citizens, certainly have played

many roles. We colonized it, we have sat in judgment on ourselves and our policies and our fellow men. We've shaped our councils on the old New England town hall style. We've created a public school system in this country, managed by the educational consumers. We've opened great universities with citizen-consumer regents guiding the institutions. We've built political parties and expressed our will through the candidates. If we didn't like what our office holders did, we threw the rascals out the next time. We, the citizens, have passed laws to control business, to control agriculture when we thought that it got out of line. We've identified some services as so vital to our well-being that controls were placed upon these services to insure their stability. Water must be pure and available,foods must be wholesome and honest and do what they purport to do. The gas coming into our houses must be there when we need it to warm the home; the electricity to light it. The policeman must be there to protect the whole structure. We have come to realize increasingly that the necessity of health services requires safe-guarding them. So, over the years, we have passed regulations and we have set up codes and applied these to the health field.

Now we are looking at what the dollar buys in health services. In 1971 the gross national product increased 5.8 percent. But health care expenditures, at that same time, were increasing by a 10.7 percent factor! In 1971 health expenditures amounted to $75 billion. The largest single item in this bill was the expenditure of $29.6 billion for hospital services, or 39 percent of the package.

Certainly we are all familiar that health costs exceeded rising costs in other areas of our economy. These last increases raised critical questions concerning the very system itself. It is obvious that many employees in the health industry have been consistently underpaid. They were, in fact, subsidizing a portion of the patient's

care. Thus, a significant part of the rising cost has been caused by wage and salary catch-up.

Another cause of the inflation has been legal barriers in most states prohibiting physicians from delegating responsibilities of lesser expertize to assistants to perform. The highest paid member of the team doing what lower paid members could do. The use of para-medical personnel would result in economy. This advantage is now being more widely utilized in the health delivery field.

Strong federal interest was aroused during the past decade by health costs and services and public reactions to these. The Comprehensive Health Planning Act was passed in 1968. A major purpose of this legislation is to bring cooperation and coordination of the consumer and the provider into the complex field of the health delivery service. The coordination is based on planning. An agency is to look at the total health needs of a community; inventory the services available; identify the lacks, such as equal care for the poor, or affordable services to the middle class. The planning of the local agency is part of the total statewide plan prepared by a state health planning authority. In brief, there is a coordination of service, a cooperation of responsible agencies at the local and the state level.

House Bill 15, passed in 1971 by the Arizona State Legislature, has broadened the local council powers, giving authority to determine hospital space and service needs even though Hill-Burton funds are not being requested.

I believe that we as a group interested in allied health training must begin planning on a broader base. As the local health Council involves all agencies and the public in its deliberations, so must we begin our planning with an involvement of the many training agencies on a statewide basis.

I sketched in my opening remarks the participatory

characteristic of our American system: the New England town hall approach, our own Arizona academy town hall; the council involvements of citizens and the involvement of the planners for manpower training in the future. Today the health delivery field has been brought into the framework of participatory democracy. Health services do belong to the people. Every man at some time needs health service. It belongs to the people, to the consumers, to the users, as well as to the providers.

Areas of interest in the comprehensive health planning approach have been identified: such as hospital space needs, the space being determined by the kinds of programs that would be offered; interest in environmental factors, certainly, such as narcotics. Other factors such as narcotics, alcohol, hospital rate considerations. Task forces of people, all kinds, have cut across the whole structure of our society and have been striving for a broad representation so that there can be a distribution of knowledge to all levels and a resulting advisory role.

Thus our conference raises the question: "Are we doing any cooperative planning to determine the kinds of skills and the numbers needed for our state? Are we doing anything to bring about a relationship of agencies and training experiences? Is the Health Planning Authority, is the local health council, are the training institutions--like the hospitals, the proprietary schools, the universities, the community colleges, the secondary schools, the retirement centers, etc.--are they really working together on a cooperative basis?"

The answer to the question about cooperative planning is "No, not to the extent that it must be done." A plethora of questions need answering. What agency or agencies should coordinate the planning in the future, should give to it leadership? The regional medical program? Should it be the State Health Planning Authority? Or should it be done, in each case, at a local level and then coordinated at a later time? What is the role of the State Health Planning

Authority? That is to be determined. What kind of input must there be if we work cooperatively? Input from the local councils; from the training agencies such as you represent today, many of you? From the employing agencies, the agencies that will use these people? Even a more specific question comes to mind: What manpower needs are best met by the universities? By the community colleges? By the secondary schools? By the proprietary schools? Are there areas in health training that the hospitals must continue to serve? Or should the hospitals pass along most of the manpower training to other agencies? Should the hospital patient pay for the training programs? Is that part of the bill? Should there be a concerted move to place all or most of all training on those agencies with a broad tax base like the university with its access to state and federal funds? Like a community college with its support from local, state and federal sources? If such transferred responsibility is given to public training agencies, what assurance of quality control is there in these training programs for the hospitals, for example?

Now these and many additional questions need answering certainly. As always, there is a need for data to make good answers possible. Cooperative planning? The improvement in cooperative planning is an imperative!

Long past is the time that an institution or an agency can stand on its own resources. Just as we can't afford as individual agencies all of the resources that technology has brought into the field and had to share these resources with each other, so must we share our planning. We have a state that supports well its training agencies like the universities and the colleges. We have a state vocational department ready to give guidance and resources. Cooperative planning is a myth at this time, but it can and will be improved and made into a reality.

I could cite experiences of ours in Maricopa County. The community colleges have worked with the hospitals, with the nursing league, with the medical society, in building programs in fourteen para-medical fields. These are based on cooperative planning. The program costs have been spread and cooperative planning and cooperative funding shared by participating agencies.

The detailed planning blueprint, however, has not been drawn for the state. How do we come up with this blueprint that indicates to each of our agencies the role that we best can play? Who puts his pen to the goals that we need to achieve, the objectives toward which we strive? The needs, the responsibilities-- who should meet them?

Today we go to work on that problem. We must work toward cooperative planning and operation. I hope that by the time we drive back to our respective worlds tomorrow afternoon that we carry back the beginnings of some kind of a plan. I urge that we agree to meet again to formulate a system that will bring together all of us in the allied health training fields to do the cooperative planning necessary to an effective state-wide training program.

Dr. Robert Mytinger:

"Arizona's Plan for Health Services"

One year ago, almost to the day, the Arizona Legislature enacted House Bill 5, which immediately set Arizona apart and well ahead from all other states in the nation. House Bill 5 mandates the Arizona Health Planning Authority to produce a plan for health services for all Arizona citizens. Three basic specifications in HB 5 were set forth as follows: (1) there should be no separate system for a specific population group. In other words, a total system of health care for all citizens of Arizona was called for; (2) there should be provided multiple choices of the way services are delivered within the single system; and, (3) all persons should have access, both physical and financial access, to appropriate health care. Those three specifications in the mandate set the basic frame of reference for the developments that I would like to share with you. The basic model for health services with which we are working is one which relies on a high decentralization of medical and health services; decentralizing services to a level as close to people as it's feasible to get them.

Presently being developed is the concept of "service zones." Four such zones are presently being considered. A map has been constructed which displays driving time relationships between population clusters in the State. We have determined, in terms of minutes, a weighted average driving time between all places in the State. We next took the notion of establishing primary service zones with specified driving time perimeters. Within a given perimeter, related to driving time, our feeling has been that there should be a certain group of health services which should be available to all people within that area. Experimentally, it was decided to put such services within a 15 minute radius of centers of population and

call these limited zones "primary zones." To do so, we identify population aggregates, then radiate out from them on all available roads, counting off a 15 minute driving time radius in all directions. Next a line is drawn which encompasses those points and tentative zones have thus been established. Throughout the State, these are unequal appearing zones, but in fact they are zones in each case within which people can move to services within a maximum of 15 minutes driving time. We would have used 18 minutes, or 20 minutes, or 12 1/2 minutes just as well; we chose 15 minutes completely arbitrarily.

The second zone rests on the concept that one cannot deploy all services within 15 minutes of all people. It obviously wouldn't be appropriate to have open heart surgery, organ transplantation or even hospital care available within 15 minutes of every person in the State. Therefore, a larger zone has been described which contains one or more primary zones and this is called a <u>district</u> zone. As yet, the specific services which would be assigned to these zones, or what manpower ought to be there, have not been specified. That will come later. To establish district zones, a larger radius allowing 30 minutes of driving time was drawn around each population center.

To carry this districting concept further, it was concluded that there is warranted another aggregate of services for which a larger critical mass of people would be required to support -- for example, acute general hospital care. These services, requiring larger population bases for their support, were assigned to a zone within which service would be no further than 60 minutes from all people. Radial lines depicting 60 minutes of driving time were drawn from the population centers, and these points were connected to establish zones which are termed <u>regional</u> zones. Thus, the completed picture is one of a sandwiching of zones, smaller ones within somewhat larger ones, within even larger ones.

As for the fourth zone, we are viewing the fact that there will have to be identified a few <u>base</u> service centers

for the highly rare, costly, very exotic kind of medical services that are best reserved for highly specialized centers. And that completes the basic model of decentralization of health care services.

The primary zones are viewed as the portal entry into health care for all people. In other words, one might enter the health care system through a care-giver who is as close as 15 minutes, and then, if need be, have freely available through that contact all the other services that rest in any of the other larger zones, depending on the need of the consumer.

We are also attempting the construction of performance specifications which would depict the ways in which any service in any zone is delivered in terms of such factors as convenience; accessibility; the degree of dignity that must be demanded when services are delivered; the quality; the completeness; the comprehensiveness; the availability. The foregoing are nice words which so far have defied precise definition; we are trying to establish a series of documents which will represent such a precise definition.

A general statement of performance requirements will include the specification of the various zones just described. It will include a number of other specifications which I would like to come to later. Parallel with the zoning project, another project will, at least tentatively, allocate to one service zone or another the major procedures or services which go to make up the total spectrum of health and medical care services. So far, about 3,000 independent or individual procedures or services have been identified. For example, about 1,350 surgical procedures are detailed, 346 laboratory procedures, over 200 pharmacy procedures, nearly 300 dental procedures, and so forth. Presently a number of judges are engaged in tentatively assigning each of these procedures to one or another of the tentative service zones. As one scans the list of pharmacy procedures, for example, there are some that appear desirable to make available to all people within 15 minutes. For other procedures, people

might travel as much as 60 minutes because of the non-vital nature of the service. There are yet other things which ought to be no more than 30 minutes away from anyone. Thus, we are allocating procedures over the same kind of zoning that was discussed earlier. Once that proximity allocation of procedures has been achieved -- and the highly tentative nature of the first allocation cannot be over-emphasized -- it is then proposed that aggregates of procedures be examined and decisions made as to what equipment and what physical resource would be required in each place in order for those procedures to be carried out.

And now we finally get to manpower issues -- for each procedure assigned to any zone, all of the existing and potential providers of that procedure will be identified. It isn't difficult to identify for each of the 3,000 procedures who the existing providers are. In many cases, the law specifies who the provider shall be. In many cases, it's tradition. We plan to go further, and here is where a great deal of help will be necessary. The plan is to determine what people might have their existing responsibilities broadened to take on some of these procedures, and which procedures are amenable to assignment to as yet undeveloped people: the new careerist, the newer kinds of health manpower mix to optimizing equations, and try to project an optimal mix of manpower in given zones to provide the specified services for each. Minimum and maximum estimates of manpower will be provided and adjusted to the needs of various populations. At that point, once these very coarse, crude and very tentative allocations of procedures and services are made, and with the associated manpower figures, one is in position tentatively to project or predict the specific numbers and types of manpower necessary to provide these services. Here is where the problem of manpower training planning comes into play. The educational system will then have available a reasonably well defined target toward which to work. It should no longer be faced with the dilemma of saying: "well,

we know we need nurses, so let's produce more nurses; we know we need doctors, so let's produce more doctors." For the first time, the education system will have a reasonably quantified target of the number of personnel needed for specified kinds of functions, in specified kinds of places. The education system might then be tailored to produce specifically the manpower commodities the total system needs, not necessarily those which have been traditionally employed.

So much for the current state of development of the Arizona Plan for Health Services. Permit me a few additional observations. With the general notion of the basic model for health services in mind, it should be clear that the public as trainable health manpower is an important ingredient. It is clear that the Plan envisages departures from tradition and from contemporary medical practice. To be specific, it is entirely logical to assign certain medical procedures, at least at the primary zone level, to the people themselves. In other words, the self, the family, the individual citizen of Arizona should properly take his place as an element in the total spectrum of health manpower. There are many things people can do for themselves and for their families, and reliance on self and family becomes an important manpower consideration in the Arizona plan.

A second important consideration which has philosophical overtones is the acceptance by the consuming public of other than physicians, dentists and other care-givers to which they are traditionally oriented: the acceptance of the nurse practitioner to do many things; the acceptance of one's neighbor to do some things; the acceptance of a pharmacist to do something other than labelling and dispensing prescriptions, etc.

In order to implement a plan such as has been described, it seems to me that a group like this has a few important things to consider in terms of action imperatives. First, the members of the consuming public need to be educated in self-care and self-help. In a manner of speaking, the career ladder in the health professions may begin with one's self and one's own home. A few elementary medical procedures can

be learned, a person can be trained to become a form of medical practitioner himself. Presumably, if the career ladder concept is built, one could move on if he wished into other aspects of medical delivery.

Secondly, the public generally needs orientation to the skills, values and the qualities of newer health workers.

Third, and this relates to one of the basic goals of HB 5 which mandated the Plan, there is a need for education of the public to foster acceptance of principles of prepayment for medical services. The appropriate targets are the existing decision-making, consuming public, and the future decision-makers, the children, the young adults who are moving into decision-making competencies of their own. Thus, from the point of view of the Arizona Plan for Health Services, the challenge to the educational field is twofold: to prepare the types and numbers of manpower which are required by the system as projected in the plan; and second, to educate the public, both to meet its health care responsibilities and to assimilate newer forms of health service delivery and financing.

Eugene Dorr:

"Career Education and its Implication"

Mr. Dorr's speech was not available at the time of publication. This paper will be distributed at a later date.

Representative Sam McConnell, Jr.:

"Spectrum of Health Manpower Needs"

This conference has been discussing the problems of training manpower for the delivery of health services throughout the State of Arizona today. As a Representative of a rural district, containing such communities as Winslow, Payson, and my own home--Williams--I am concerned equally about the distribution of these trained health personnel to our smaller communities. It is true that Maricopa and Pima counties represent the major population centers of the state where, consequently, the greatest demands are made upon the existing health services. Even though there are massive demands for health care in these two counties, the result of these demands has led to the development of many health resources--specialists, clinics, hospitals, and all available within minutes to residents of these two metropolitan areas.

But let me describe a problem which has a tremendous impact on the delivery of health care in small communities and rural areas which will affect the training of allied health personnel in Arizona and the delivery of health care to all of the people of Arizona.

Let me illustrate with an example from the community in which I live. Five years ago, we had three physicians. One of them, because of health reasons, has retired. We were down to two. One of the two has been ill--has had a leg amputated and is now unable to practice hospital medicine. He can still practice medicine in his office. The community population is 3,000, but the same thing can be true of communities with 5,000 people. You almost have to get up to 30 to 40,000 people to be able to afford all of the equipment that's necessary in a major hospital. But in this community, one, then can't practice in the hospital. So that leaves the last physician unable to work all day and be on 24-hour call for emergencies, seven days a week, and physically he can't stand up to that.

Now, we have tried to get another physician to come into the community. We had one for a short period of time and he had a better offer from another community that had a larger population--a hospital owned by a physician--and so he went to work as an employe of the other physician at a sizable income. Now in order to replace him, we've tried everything in that community possible to provide another physician--even to the point that we have tried to hire persons to come up and fill in on a weekend.

This may be hard to believe, but we contacted one physician in a neighboring state who has been doing emergency-room work. He agreed that he would come to our small community. Yes! He would cover the hospital 24 hours a day for emergency services on a salary basis--that salary, $10,000 a month gross with all expenses paid. Now I don't believe that there are many physicians in this room, and I am sure that there are very few who would do the slight amount of work that this physician would be required to do, or who have as little training as this person and can expect to earn $120,000 a year, or even half of that figure. But this is an indication of the problems that are being faced in the rural and non-metropolitan areas of Arizona. I have used an example of a community that is 30 miles from a metropolitan area--you can cite the same circumstances for communities at greater distances from a metropolitan area.

What are the causes of this situation? Why do small communities have a difficult time keeping trained physicians and what impact does this incident have upon a conference such as this one, which is concerned with the training of health manpower? The reasons are many, but let me continue with a discussion of some of these factors.

The primary person necessary to head the allied health team in caring for the sick patient is the <u>physician</u>! The physician is the supervisor, the one who must direct the overall program. Now, unless that supervisor is available, you can train all of the ancillary help--all of the physician's

assistants, the nurses, the lab techs, the physiotherapists. Any type of allied health person can be trained, but unless the "supervisor" is there, those people either are not going to be there or they are there without a purpose. Basically, metropolitan Phoenix, where they have major hospitals, Tucson, Flagstaff, Prescott, Yuma--these are the only real metropolitan areas in the State of Arizona which can provide total health care needs for the people who are in their area. In these metropolitan areas, we are talking about the kind of health care that you see on television, whether it's the Dr. Welby team who are all getting results--all working hand in hand, the patient walks in and he immediately takes him to the hospital, which is a short drive away, or he says, "I'll meet you at the hospital. Go down there--they have all of the services; they have all of the specialties represented, and there, they have all of the allied health team which is needed to provide care"--but in the rural area, in the non-metropolitan area, whether it is a short or long distance from a metropolitan center, it is a fact that you cannot get a physician, the head of this team, to establish a practice, and it has become increasingly more difficult to do so in the last five--ten years.

One major reason why doctors are avoiding rural communities is their concern for possible responsibility for medical decisions which go beyond one man's capabilities. When people enter these small hospitals because of accidents or emergency illnesses, they expect total care. When one or two doctors make a medical decision, they are now concerned with the patient's reaction to these decisions.

When there is some question of the utilization of proper medical techniques, even if it were one out of one hundred cases, or even less, percentage-wise, there can always be someone who would develop a case that his health care was not satisfactory. They, then, may sue that doctor, sue that hospital, sue everyone connected with the case, for malpractice. Quite often the people who sit on the juries award a large judgment to that individual because that doctor did not, in the

opinion of the people on that jury, take all of the precautions necessary by sending that person to a metropolitan area where there would have been a specialist available for consultation or assistance.

If, for example, you are in a small community, such as Grand Canyon, and you go into a hospital there with approximately 30 beds, which is only 68 miles from Flagstaff (a metropolitan community), but in that small hospital--60-75 miles from the metropolitan area--the physician, if he has an accident case with a compound fracture, in one case out of a hundred, that he could, and normally would, try to correct, considers it not appropriate to make such a decision, since he is fearful that he is going to face malpractice suit for all of those hundred cases--he is going to send them on to the metropolitan area hospital where there is a specialist available for consultation and assistance.

Because of that problem, doctors are very reluctant to go into small communities and set up practice. First, they don't want to face the possibility of a malpractice suit. Secondly, most doctors, after having received medical training, want to go into an area where they can have a challenge; where they can treat their more exotic cases and feel that they don't have to send them on to someone else to take on that responsibility.

In the smaller communities, you cannot use allied health persons if there is no doctor. You will also have the more routine kinds of cases which may not require the Dr. Welbys and the more vigorous allied health persons.

The physician who is practicing in a rural community does not have the cases which are generally speaking, challenging. And therefore, neither does his nurse. Or, if it is the anesthetist, the anesthetist has very little opportunity to work because the physician is hesitant to do any major surgery. There isn't enough surgery available to have a surgical specialist there and this, too, is one of the problems that we have to face in that the colleges today are training their people primarily to become specialists. There are fewer and

fewer general practitioners available to go into the rural areas; there are fewer and fewer general practitioners who will establish themselves in the rural areas.

A problem related to the communities' size and isolation is the inability of that community to support the medically trained specialist. Small communities cannot support an orthopedic surgeon nor have a cardiologist, nor have interns, nor have an ophthalmologist, nor a neurologist; nor is it possible to expect that when a general practitioner is delivering in a maternity case and he runs into a problem, he can call an obstetrician and that obstetrician can be there before that delivery is completed, thereby reducing the danger to the mother and child.

People living in a metropolitan area go to their regular family physician--and if the man has been in practice and is a general practitioner--not a specialist--they go in and don't question the fact that he can provide the service that they want--and he doesn't question that fact either, because if he takes that person into the hospital, or, if in his diagnosis, he sees some problem which causes him concern, he can either send that person immediately to a specialist, to an internist, to one of the other specialists; or if the patient is in the hospital, he can call for the assistance and consultation of a person who can be there within 20 to 30 minutes. But, when you are in a non-metropolitan area, try to get one of the specialists to come for a consultation. There are many of them who will serve on a consulting basis to the small community hospital-----but not to the point that they are willing to stop their own practice and come over 30, 50, 60 miles to assist and, if they were willing, time doesn't permit them to do so. But in a metropolitan area, there is someone close enough to that major metropolitan hospital that he can be there with the information that's needed.

And, this is why, I say, that we in Arizona have not provided for total health manpower needs.

How can we possibly solve this problem of providing

a health care team, headed by a physician, to the rural communities of Arizona? Should we have Williams High School, or Morenci High School, or Yavapai Community College, or Northern Arizona University train allied health persons if we cannot recruit committed, permanent physicians to work in these non-metropolitan areas?

The colleges of medicine today are not training general practitioners--they are training doctors to graduate and become specialists. Most of the physicians that are practicing today, who are over 50 years of age, can remember that, if they went into a residency program, they could expect to work for one, two, three or four years as a resident for $100 a month. Today, a resident can expect to receive up to $16,000 a year while he is getting that specialty that is going to make him more valuable in a metropolitan hospital.

These problems combined say one thing--that is, that there is not a comprehensive health program available to the person who is living outside of a major metropolitan area. It is becoming increasingly difficult to replace the physicians who have moved from small communities and have become established in metropolitan areas.

The State of Arizona is looking at several options to overcome this problem. One consideration has been that due to the cost to the taxpayers of training physicians at any medical school, that there should be some way that the physician-graduate is encouraged to serve a period of time in a non-metropolitan area in an effort to repay this tax money which has been spent for his education. Now, there are considerations that may have been mentioned by an earlier speaker. A solution such as voluntary program should be encouraged. As a Legislator, it is my opinion that the physician-graduate should be required to serve a period of time in a rural area. Under the WICHE program (Western Interstate Commission on Higher Education), the physicians who graduated from the WICHE schools with a medical degree had the difference between instate and out-of-state tuition paid by the taxpayers, and they were required to return to

the state of origin and serve for a period of five years, or repay the state for that difference that was expended. Now, it would be almost impossible to expect a physician who is receiving $60,000 worth of education to repay that $60,000 over a short period of time, but it would seem to me that they could be encouraged or required to serve in the areas that need physicians for a period of time to offset some of the tax expenditure incorporated into higher education.

Another consideration is the use of foreign physicians who would be licensed to practice in the State. These physicians might be encouraged to practice in rural areas. Also those physicians who have retired could be encouraged to offer their voluntary service as a community service project to assist in providing health care to rural residents.

Let me summarize: We are gathered here to discuss the training of allied health manpower. The training of these personnel is fruitless to the small community unless there is a physician in the rural area to head that medical team.

It will be difficult to encourage high schools, junior colleges, and universities to train these specialists except for metropolitan areas, unless there is an adequate health care system, developed in Arizona's small communities. At the time you ensure that physicians will be located in rural areas, at that time, only, can you develop the public school systems' enthusiasm and interest in these small communities to train allied health persons.

Dr. Irwin Spector:

Collaborative Roles in Preparing Health Manpower -

"Educational Institutions' Viewpoint"

When I get done with my 15 minutes, I think I'll know what I've said. When I was asked to speak on this panel, I said I have some things I have wanted to say that may have been bothering me for a long time and haven't been said. Since that time as Dr. Donaldson indicated, I have assumed a new role as President of a College and I guess that means that all I can say are things that don't mean anything because I must be political and not offend anyone. But, I'm not a President of a College yet. I'm still an Executive Vice President, so I'm going to say some things I've wanted to say. And I'm not going to say, hopefully, things you've heard before because that would be wasting part of my 15 minutes.

Talking about the collaborative role of what education has to do with the health field really can't be done unless you talk about the health industry itself. The health industry today is in its industrial revolution. It's going through the throes of what other industries went through some 30 or 40 years ago. It's coming out of the cottages and coming out of its apprentice training programs; coming out of small individualized types of instruction into the field of mass education. What causes the reaction toward mass education? Well, it's the need for a greater number of personnel; and the obviously expanding role and need for health services and personnel. And overlying all of this is money. There's nothing wrong with the system that we have now, in a sense, as long as we have enough money to keep operating. But there is a heavy fiscal crunch, dollar crunch, which is causing a change in the system. Along with that change in the health industry, there is a change occurring all over our nation, in lots of ways.

I think we are beginning to think that health is a right that everyone has. It's the need for an equal benefit and an equal delivery system. We crossed this bridge in the area of education in the 1800's. We said that education at some level was a right that everyone had. And we set up a system which provided these educational "goods" to everyone. I don't know that there are any absolute "goods" and absolute "bads"; however, whenever you try to do some things to achieve certain corrections of our society, you undoubtedly have achieved some things which are not the best. I'd like to make a parallel for a moment between the health industry and education, which is the cost to operate the systems. And we've taken two different approaches in a sense between the health industry and the educational industry. In the field of education we've generally started with the amount of dollars that we've provided to the educators, and we've said to the educator, "Now, you provide the best quality program that you can provide for those dollars." And we've operated within a dollar restriction of budgets. No one said to us in the past, and this is part of our dilemma today, that we have to attempt to achieve 100% effectiveness with 100% of our students. So the system operated fairly effectively with certain students doing well and certain students being spewed out of the system. What's the public saying today about education? They are questioning in some ways our quality and our effectiveness, but they are saying we are too expensive. And they are saying kind of a reverse thing about the health industry. They are saying, "Your quality may be fine, but you are too expensive." It's very difficult to achieve both high quality and low cost. I'm not for a moment indicating that if they gave the educational establishment twice as much money that our quality would increase to that extent. And in education, we've accepted the fact, at least in the past, that there are going to be certain failures and losses. It's an odd thing about our country, and maybe people, in which we are seemingly willing to accept psychological damage to people, cultural damage to people, damage to people in terms of living in their society, and we maintain

that we can't afford to carry this effort. But in the health industry we want to save everyone and keep them physically healthy. Seemingly there is a dichotomy of concerns here.

As you're going through your industrial revolution, as the roles are changing as to who does what, there are obviously stresses and strains being placed upon the individual. Role changes, changes in style, changes in direction, do not come easily to either individuals or institutions. I don't think there is any question--there's no question in my mind--that education can train qualified para-professional personnel at a lower cost than is now being generally done by the health industry. Programs should have the following parameters to operate properly: there must be a body of knowledge. This body of knowledge can be theoretical, it can be operational, perhaps, and it can be manipulative. And if there is a body of knowledge, then we can and have shown the ability to develop curriculums to train entry level personnel. The other thing you must have before we can become effective, both in an educational sense and fiscal sense, is a sufficient number of people being trained in any one of the areas, for which we are developing curriculums. I asked myself certain questions and I hope you will appreciate - I don't have all the answers either - but I'd like to raise some questions with you, and maybe later on we can have some dialogue. What makes the health industry different from many other industries? Why is it perhaps the only industry that is left, that in a sense, is training its own entry level personnel? Someone may say to me, as they have in many advisory committees I have sat with as I develop curriculums, that we are dealing with human life. Okay, I will accept that as a necessary parameter that has to be fed into the construction of the program. Frankly, I'm not quite sure that the difference is as great as you are indicating. One thing that also occurs on these advisory committees is this question of knowing what the manpower needs are before we start developing programs. That's the same

question I got eight years ago when I started developing allied health programs at the community college level. We didn't know what the manpower needs were. We don't know them today. And I tell you we don't know what they are going to be eight and ten years from now. We don't know it, not only in the health industry, we don't know it in any of our industries. And I wish we would. I'm not advocating at all a willy nilly development of programs without some basis of fact. But I defy anyone to tell me precisely what the health industry manpower need is going to be in five years, or what its health needs are. It takes us five years before we turn out anyone in any realistic numbers in any curriculum. Find out the facts, but don't get bogged down or stop just because we can't get a handle on the manpower needs. The Maricopa district didn't have all the answers in terms of the needs of inhalation therapists, and medical technologists, and radiology therapists, and unit clerks, and the 13 different programs we have with 1,000 students in it. But I can tell you that the students are being placed and the jobs are there.

Someone may say health programs are different because they cost too much. They do cost a great deal. However, it may depend upon how you do your accounting. Our health programs are the most effective programs in terms of retention of students and placement of students. Our unit cost may be high, but our cost per placement is probably one of the lowest cost programs in the institution. In terms of facilities, I'm not advocating that the educational institutions begin duplicating what is already available in the community, and this IS the one distinction that is different between the health industry and other industries. It would appear that in most of the training programs now available in the univeristies and colleges, that we are able to duplicate experiences for the types of skills necessary to perform at least minimal acceptable entry level capability without large expenditures or duplication of industry facilities. This doesn't seem to be quite as easily done in the health field. So I accept that in this way, the

collaborative role in education and the hospitals and the other health facilities within the community is necessary. The allied health programs being developed must fit into the clinical resources for which the training programs are being developed. I accept this admonition, and it's a major area that needs joint cooperation. What does the health industry have to do when we use their facilities, besides making them available? The hospital industries' role is to insure that the students work in conditions in which the role models they observe are good models of the health delivery system. It is probable that when they become practitioners they'll do probably not what they were taught but what they saw.

In the area of licensing and regulations, I've fought those battles; we all recognize that these regulations do exist and our curriculums in some sense are guided by what external agencies have said. I've sometimes wondered about the archaic aspects of certain of these licensing and regulatory regulations, but that is not an area that I can affect. Certainly these regulations have an effect upon curriculums, which then have an effect upon staff, which then have an effect upon facilities and students. Obviously some of the regulations are reasonable. Some of the regulations are not reasonable, and are not in tune with the needs. They are protectionist.

Let me say something about the problem of urban and rural distribution -where the manpower is and where the needs may be. Should we have a master body determine when programs are needed and how many programs we should have in terms of output? Let me preface my remarks. I've operated on this premise. It says that the training of most health professionals should be done outside the health industry--should be done in educational institutions. Now this doesn't get the health industry out of the educational process, but changes their role in terms of preparing entry personnel. It may even change their role in the development of continuing education; where the aspects of continuing education are relevant across

the whole industry - not where they are relevant to the peculiarities and the differences in the particular hospital or aspect. For example, when we went into a program in x-ray technology, what we found aside from the fact that the staffs do not want to give up their programs in the hospitals, but DO have some concerns about costs, they are reluctant really to get out of the education business. We found programs with two and three at one hospital, two and three at another hospital, three and four at another, one and two somewhere else, and we brought them together and went through that body of knowledge I referred to previously, at least in the class of 12 to 15, which seems to have some cost effectiveness. I think the same parallel may exist in the development of continuing education--for radiology or inhalation therapy or nursing, or whatever. There is a body of knowledge which is new to the field, and not necessarily unique to the hospital. This becomes especially true if we are talking about the rural hospitals or the small hospitals. Their chances of upgrading their teams are practically negligible, unless we collectively bring the people together to go through this body of required knowledge. And how about the entry jobs in reference to urbanicity and rural programs? I'm not really too concerned about over-producing health personnel--if I can believe what I read, the biggest industry in the United States in the next decade is going to be health. Why are we so concerned about the possible excess personnel? We are not training people for Arizona only, we are training people for this county. If we happen to over-train a few people in the urban areas, in my mind that's one solution of how you get people to the rural areas. As long as there are jobs available where the lights are, then you're not going to get some people to live in the other areas. When people want to work in the health industry, and when the choice is no jobs in Phoenix but a job in Snowflake, I guess they will begin to go to Snowflake.

In terms of Arizona programs, there are probably only going to be two major health training locations that can properly be supported by facilities, health training programs for health manpower. So, the degree of coordination in our state becomes relatively simple in terms of how many programs and where they are going to be. We can nicely divide ourselves geographically. Yes, there is a need for coordination; yes, there is a need for dialogue; yes, there is a need for non-duplication. I'm not as concerned about some of this duplication if the educational institutions get into it, as I am about duplications between education and other areas. As much as some lay people may believe that education really doesn't spend its dollars very well, I will tell you that you will probably not find much duplication in the state of Arizona in terms of excess health programs even without any coordination.

I've tried to play the devil's advocate role today. I'm not quite sure of the need for a centralized coordinating body; or that legislation is the mechanism to correct the ills of what's happening now. The health industry is going through its industrial revolution - it's going through the trauma of change. No other industry has used as its solution a coordinating, centralized system. Even education, has gone to an overall single body, state-wide decision-making process.

I'd say, I'd like to try coordination and cooperation but I'd be hesitant about going to legislation and centralization from a state body in terms of this solution. I don't believe everything I've said--exactly or entirely, but I hope I've raised some points for you to consider.

Betty Ord:

Cooperative Role in Preparing Health Manpower,
Health Practitioners and their Associations

This morning I will try to bring together for you some of the thinking in terms of health practitioners and their associations.

Health Associations today are being given many descriptive phrases and names, some of which are not too complimentary. There is bombardment on every side with what's wrong with associations and of the impediments that associations carry in terms of health planning. However, health associations and many of the professional associations began with some very idealistic and high-powered goals and thinking in terms of the total approach to health manpower situations throughout this and other countries.

In general associations of health workers are defined as voluntary groups to:

- promote and guide development in their respective fields
- set standards for education and practice
- certify qualified members

Constructively one must look at these associations as providing, promoting and guiding the development of their respective fields. Some of the professional associations have very long histories in terms of doing this. Many would admit that numerous mistakes have been made, but they have been in the business since the early beginning trying to provide the kinds of things that they, as professionals, have felt were essential to their respective fields. The various associations have made large contributions throughout the years by setting standards for education and practice. Many have their roots in the formation of guilds and even apprenticeships that began by setting standards applicable to their own profession.

Another recognizable aspect of the professional associations' activity is the certification of qualified members.

This had led to the development of strong, diversified, specialized groups such as the American Medical Association, American Osteopathic Association, American Nurses Association, American Podiatry Association and at least 22 other associations for allied health personnel. Each of these associations has accepted and clung tenaciously to the right to determine the functions falling within their specialty and give recognition to their membership. In addition, the development of guidelines for specific fields of allied health workers have brought certain groups of health workers under the aegis of strong professional associations.

The desire of practitioners to raise their status to gain public recognition of their competency and maintain standards of character and honorable practice has led to strong national groups of associations as well as strong groups at state and local levels. The professions have sought control over their own works and created behavior that is enforced by their peers. Professionals have been able to achieve status and power through this kind of an association. We must deal with this when we talk of collaborative roles.

Associations have also led us into several different types of legal or recognizable characteristics that I know Dr. Thompson will speak further about later this morning. I would call attention to three classifications that must be dealt with most commonly today: accreditation, licensure and certification. All have been developed or are strongly influenced by the professional association.

- Accreditation - recognition of an institution or program as meeting predetermined standards
- Licensure - government permission to engage in a given profession or occupation
- Certification or registration - agency or association recognition of an individual having met predetermined standards

All of these are recognized by associations as ways of insuring public safety and welfare. Today these same matters are being looked at by public and private leadership with high

degree of accountability. Are the standards set by the professional associations doing the job or are they providing the roadblocks to manpower development and delivery of health services? Are associations and professionalism a process detrimental to constructive change or can they be positive forces in the development and enforcement of high educational standards for health manpower? Individually and collectively we must face these questions or they will be faced for us. This is not an easy task for when practitioners of different sets of training come together there are many strong and very abrasive contacts, almost a battleground.

The structure of professionalism or associationalism must be put aside and the problems of today must be dealt with by all in a collaborative manner. The question before us then is, how in the future can we make the contact of professional associations, education, health providers and the public become creative and innovative, and hopefully provide the essential health manpower? Mechanisms for this must be sought at a local, state and national level.

It seems obvious that the joining of allied groups in a peer relationship for planning and activity will require a great deal of give and take and is not something that can be accomplished easily.

Recently there has been published by HEW a report on "Licensure of Related Health Personnel Credentialing" that makes some broad recommendations for the health manpower system. A Study Commission, SASHEP composed of the American Medical Association, the Association of Schools of Allied Health Professions and the National Committee on Accrediting have recently completed a report that will present conclusions and recommendations affecting educational programs. Study of these reports along with others might be an effective collaborative beginning for all of us. With the increasing number of health occupations seeking education and recognition, it is also essential that state, regional and local groups be required to develop criteria by which legislation can be evaluated. This criteria should include the demonstrated need for such legislation by the health practitioners, providers

and the public.

I feel the theme of the 70's is accountability. The professional association must be accountable in new and different ways to the public; accountable to their own profession and in many different areas and accountable to themselves for the task before all of us -- sufficient quantity of competent health care personnel.
Thank you.

Dr. Hugh Thompson:

Collaborative Roles in Preparing Health Manpower -

"Licensing - Certifying Boards"

The question of certifying, licensing, and registering workers in allied health fields has been a concern of education, government, and the health industry for some time. It is important to have the public protected. Employers and patients must be assured of the competence and training of those who serve them. This is more easily possible when people have a recognized degree at the Baccalaureate or higher level from an established college or university. But below the Baccalaureate level are an increasing number of persons who have received an associate degree or certificate from community colleges, vocational schools, after a course of one to two years. These graduates may have the same generic name; for example, "nurse," as those with a Baccalaureate degree though their levels of knowledge and competence obviously vary greatly.

There are a considerable number of health occupations such as dental assistants where training for many has been solely on-the-job by individual employers. However, there are also formal education programs for these people. The employer can distinguish between those with formal and informal training but the public usually has no way of knowing the background of the assistant.

The new occupation of Physician's Assistant is a particularly complicated one. In the past, physicians have used all manner of people to assist them in the office, from highly skilled professional nurses to high school graduates, or their wives, with minimal on-the-job training. Now by capitalizing the words, Physician's Assistants, one designates a group of people who have had experience of varying degrees in some health field in the armed forces, and then some additional training.

Now they are mostly male, although both, men and women,

without armed forces experience are being admitted to some of the training programs. These programs vary in length from 15 months to four years, and may offer training in the broad field of family practice, or in a narrow subspecialty area such as urology or orthopedics. The graduates of such programs, however, may all be called Physician's Assistants. To further complicate the problem, the small number of graduated Physician's Assistants, and there are only between 200 and 300 now, wish to be officially recognized as Physician's Associates, a title which they feel will give them more status and more accurately describe what they visualize as their function. The American Medical Association, and doctors in general, are opposed to such a title since the word "associate" ordinarily has been applied in the past to other physicians who work with the doctor.

Two or three social trends make accurate identification, labeling, certification of allied health workers important. The first is the urge to provide employment in the health fields for the disadvantaged who had relatively little formal education. Neighborhood Health Centers, the Indian Health Service and similar organizations are training family health workers, laboratory technicians, Physician's Assistants, and so forth. Some of this is within the framework of an established educational institution, and some without. The results are obviously people who are going to have some trouble being identified when they move from Arizona to California. Californians are not going to know much about the graduates of the Neighborhood Health Center in Tucson. There is no commonality.

The second trend is a desire to have both vertical and lateral mobility in the health industry. This has always been somewhat possible above the Baccalaureate level. There is now a major drive to make this increasingly possible below that level without forcing the individual to start at the beginning with retraining for a new career. Standards and certification to protect the public, guide the employer and give proper recognition to the employee is therefore a most

important procedure. Identification of people in the health industry may be accomplished by certification, licensure, registration, accreditation of programs and association membership. We'll briefly discuss these terms and then address ourselves in particular to the control to be exercised on the new category of Physician's Assistant, particularly in Arizona.

As you know, certification refers to an evaluation of persons meeting qualifications for that occupation specified by the professional association for that occupation, and is primarily concerned with the competency of individuals to perform on the job. Like accreditation, certification is largely carried out on a national, voluntary basis by professional organizations and agencies. In contrast, licensure usually involves government, is not optional or voluntary, is usually administered at state level, and usually regulates, or offers a vehicle for the regulation of the activities of the occupation being licensed.

About 26 occupations in the health field are licensed in one or more states. And because of the flaws in licensure, the American Medical Association, the American Hospital Association, and the government, have all suggested a temporary moratorium on the licensure of additional health occupations and are collaborating in a study to establish national commissions to come up with a solution. The reasons are rather obvious. If you license a person, for instance, as a pulmonary therapist, this person may go to Willcox, or Benson, or Kingman and should function there not only as a pulmonary therapist and inhalation therapist, but also as a physical therapist because that particular community can't afford two people. But if they are only licensed to do one thing, they are in a bind. If they do something else they may be illegal.

Now, accreditation is something that so far has been established by the American Medical Association for certain health occupations. Again, it is the American tradition that this has been the responsibility of non-governmental voluntary accrediting agencies. It is this process that is sorely lack-

ing in the field of Physician's Assistants but again the American Medical Association and the American Hospital Association are working toward the accreditation of programs at the present time.

Registration is another function which is ordinarily carried on by a certifying agency. This agency provides a method of meeting the needs of communities and physicians and health institutions to obtain the proper workers for them and for the workers to find jobs.

In Arizona, the legislature has just legalized the use of Physician's Assistants. Physician's Assistants are being legalized all over the country and the process usually has two steps. One is making an exception to the Medical Practice Act to codify the physicians' legally recognized right to delegate tasks to competent allied health personnel. In our state this has been accomplished by saying first that "this chapter shall not be construed to apply or inhibit any acts, tasks or functions performed by a Physician's Assistant -- provided that the Physician's Assistant is approved by the Board as one qualified by training or experience or both to function as a Physician's Assistant," and second, providing that "the act, task, or function is performed at the direction and under the supervision of a licensed physician in accordance with the rules and regulations of the Board."

The second mechanism usually used by legislation is a broadening of the powers given to the state boards of medical examiners so that boards may approve training programs, certify graduates of approved programs and/or approve applications submitted to physicians to utilize one or two certified graduates. In this state the legislature has done something rather interesting. It has put two boards together. It has put the Board of Medical Examiners and the Board of Osteopathic Examiners together under the chairmanship of the Dean of the Medical School with the idea of accomplishing a second purpose - to bring medicine and osteopathy closer together. These two boards together are to provide guidelines and regulations for the certification of not only Physician's Assistants, but also for the doctors who employ them.

So in Arizona and in some other states, not only are the assistants certified, but you also certify that the physician may use an assistant. This has been, in Arizona at least, largely the result of one incident, where a physician utilized illegally a nurse in another community to practice medicine under his aegis, and the subsequent fear that a very occasional doctor might do this for financial gain without adequate supervision of the assistant's performance. Another reason is to give assurance that the assistant has the skills needed to perform in the specific setting. For instance, an assistant trained specifically in pediatrics should not be employed to take care of the aged without further training. This is rather obvious.

It is probable that if the program proposed by the American Medical Association for accrediting training programs becomes operational, that within a few years the curricula will be sufficiently standardized and certification of assistants so widespread, that individual states will not need to monitor each physician-assistant relationship. But there are not going to be that many in Arizona in the next few years. The state will probably start with a few dozen.

One last point on one of the problems presented by the Physician's Assistant concept. The Physician's Assistant is going to perform certain functions: history taking, conducting certain parts of physical examinations, certain laboratory work, and certain therapeutic procedures. Those same identical functions are going to be performed by nurses who have a degree or certificate in nursing, a license to practice, and who have received special training. So there are going to be duties performed by different people who have arrived at that particular level of competence through different channels. This has aroused a good deal of concern and a great many questions. The answer obviously is to be sure that people in these allied health fields and in others are competent to perform the functions which are assigned to them. And here we get into the business of examining the functions.

In conclusion, the problems in regulating the functions

of those in allied health occupations are: first to define what the person is to do, and second, to be assured that the person is competent to do that. This is going to require considerable flexibility, since what a Physician's Assistant or a clinical nurse may do, will be quite different five years or ten years from now than what they are doing now. Lastly, we must have continuing education--this is going to be one of the biggest problems in this entire field. It is certainly in the cards that anybody in the health industry from physician to a family health worker is going to be required, in the next decade or two, to demonstrate continuing competence to perform their work.

Dr. David Graef:

Collaborative Roles in Preparing Health Manpower -
"Health Service Facilities"

I'm on the program to represent the facility viewpoint. I'm not sure I can entirely do that. I've been associated most recently with a number of facilities in Phoenix and in Northern Arizona. However, I've always been associated with those kinds of operations, in and out of the health field, as a staff person, so I'm sure that what I will discuss with you will reflect a staff bias. I have some other biases that I am sure will appear, some education biases, that derive out of my schooling. I have some management perspective biases that I am sure will appear too.

Enough said, I am trying to share with you some of my concerns about the kinds of problems we face as we talk about collaborative roles. One is simply the term itself. Not only is it hard to say, for me, but it has that potential of being so attractive that it gets ahead of the programs. By way of example, I think of things like participative management, sensitivity training or consumer representation. A single term sometimes gets ahead of where the action is. Let me share with you concerns where I think the action has got to be as we try to collaborate.

One of the most crucial points that we have to collaborate on is the use of dollars. We talk about a shift from facilities doing the educating to educational institutions doing the educating. I'm all for it. We <u>have</u> made progress. I don't think it's a myth. I know progress has been made. The myth is that the progress that has been made has been the shift itself--not real dollars saved. We can show shifted programs, but can't tell you how much they are going to save or cost in five years, any more than the shift from Holbrook's cost of buying a hospital to its cost to <u>run</u> a hospital has ever been made clear. Holbrook doesn't tell themselves what it costs five years from now! This kind of

thinking is a potential pitfall to collaborative kinds of programs. We've got to do it at the very outset, I think, talk about what it is going to cost five years from now. What will it cost to run the medical school ten years from now? We at this point in trying to get together to share ideas, have as number one, a concern for telling ourselves what it's going to cost. (Hopefully, it's going to cost less! Hopefully, we can at least contain.) But, at worst, let's identify what it is and let the consumer decide what he wants--what part he wants in it. We talk about a shift in education in the health field which saves the facility money. Is the consumer ready to pay for it on an educational basis? If you look at what percentage of bond issues are being passed today, you question, with about 47% being passed, whether the consumer is ready to accept more education dollars for health. We hear that it's going to cost more, but <u>if</u> it is going to cost more, where is the money going to come from? Let's at least identify within our collaborative efforts what it will cost and who's going to pay. Speaking of neat shifts--Industry, a number of years ago, negotiated with the "troops." They negotiated benefit packages. They said to the "troops," "We will pay for these packages" and hospitals said, "We will provide these benefits." What about the cost? Well, the costs right now will be a certain amount a month. How much will it cost in ten years? "Really don't know, but it looks like a good deal to us." "This Benefit package will get you and the union to an agreement, and if you don't have a union, it will keep them off your back." So benefits pile onto benefits, and the responsibility for cost later turns out to be the hospital. I claim both parties, hospitals and industry, are to blame for not identifying the cost at the outset or at least trying to make an <u>attempt</u> to do just that. I think that at this point in education we must be aware of that same kind of problem; namely, a shift in cost. If we are shifting to educational institutions, let's try to identify what it will cost so again the consumer can talk.

Now what's another issue as far as I'm concerned? As we talk about a collaborative role, do we identify where the doers are? Do we identify where the action is? Do we identify what the politics are? Do we identify what the laws are that concern what we're doing? I personally have sat in many collaborative efforts where we simply didn't do that. When the meeting ended or a series of meetings ended, we weren't telling ourselves where we were going to get things done. We were telling ourselves we had a good idea, but we weren't telling ourselves where it was going to get done.

How about objectives? That's something that most of us from an educational base know something about and are familiar with. How about the collaborative efforts that cost anywhere from 80 to 200 thousand dollars that identify objectives very clearly, but lack any of the criterion that I've been talking about--lack any responsibility for dollars--lack any responsibility for seeing that ideas get implemented. The other side of objectives. How about those kinds of programs that we've collaborated on, where we've got the dollars, we've got the legislation and we're doing it, but we don't have clear objectives. Now, what do I mean by clear objectives and what kind of objectives? Let me use the board for a minute and talk about education evaluation in terms of (1) attitude and in terms of (2) knowledge, in terms of (3) behavior change, and in terms of (4) results--I'm going to spell out results. It's results I think are important. As we talk about collaborative kinds of ventures, I don't think we build into our conversation an evaluation process. It seems to me that one of the criterion for a good collaborative program is that it has evaluation built in. Evaluation based on attitude in terms of response from people, certainly that's an important ingredient that we have to have. How about knowledge? Certainly. How about behavior change? Certainly. But how about results? Now what kind of results are we looking for? My opinion is that <u>if</u> we are looking for results that protect our professions, we simply aren't doing it. If we

look for results that "are saving hospitals," we're simply not making it. We've got to get out to the community. In education the criterion for success in terms of results could be things like juvenile delinquency rate decrease. In terms of health--we're talking about better health--and that's where our criterion has to be in terms of good collaborative programs.

How about some others. Let me just share with you three other main points that I think are crucial. Sometimes we, in a collaborative effort, get the dollars--we get the people that can do it--we know we are covered by law--we have the objectives, but we avoid a conscious marketing effort--we avoid selling almost just the same way we tend to knock the word "profit" or knock--taking in a little more money than we spend for those kinds of programs that we need to do. I think selling has developed a bad name. I think it's one of the ingredients that's missing when we go to put on a program. I notice it wasn't missing from Gene Dorr's presentation yesterday; an important item on his list of things to do--the public relations responsibilities. And we sometimes avoid to do this. We have a tendency to say we're in the health field. We say we're saving lives. We've gone to all this work. We've done our homework. We don't have to sell. But we <u>do</u> have to sell! A very basic premise that I learned in the personnel field. I've seen programs that describe in detail what we're doing on a wage and salary basis. Technically sound. No question that our people are getting a fair rate of pay. But that's only half the effort. The other half is, do our people <u>feel</u> that it's a sound wage and salary program? If the program doesn't make them feel that it's sound, we have left out a most important ingredient.

Two more items. That of specialization. I think we're running the risk, within our own efforts on a collaborative basis, of having our own built-in specialization. Let me just give you a model of what I'm talking about. An ideal situation, to me, from the standpoint of a nursing instructor

is one who can develop curriculum for and deal with students, nursing students. In addition, she ought to be able to develop curriculum and deal with people on an in-service basis--in the facility. I think, too, she ought to be able to develop curriculum for and deal with people in the community on a preventive basis. I think further, she ought to be able to develop curriculum with and deal with these three entities on a continuing education basis. What we are getting to is a mix of education, or with their community on many levels. We've got a much broader educational person. I think we run the risk within our own collaborative efforts of becoming too specialized, and I think the key word is interchange with the community, interchange with the facilities as well as with students that are on their way up.

The last item that I have is an issue that I feel has to be faced, and we might as well face it as we talk about collaborative roles. When we talk about assigning ourselves tasks in the health field--where are the trade-offs going to be in terms of a mechanism to deliver health care down the road? There are going to have to be trade-offs. Many smaller towns are going to have to make some sort of a trade-off. They are going to have to provide a trade-off in terms of $10,000 a month for a physician, if that's what a physician wants, or they are going to have to face the trade-off of some sort of clinic rather than a hospital. I can talk about an extreme--Grand Canyon Hospital--where in terms of many in the community, they insist on maintaining a 24-bed hospital--well they've done it with government funds, but when we're talking about dollars and all these kinds of things, we eventually get to some trade-offs. Professions are going to have to make some trade-offs to an ultimate systemized way of providing health care. The facilities are going to have to make some trade-offs, licensureship will, educational institutions will. Now, I'm not saying compromising principles; there simply have to be some trade-offs. There's no management game alive that's played, and we're talking about the management of services

to people, no management game alive that's played that doesn't involve some trade-offs. Major groups that are involved in collaborating efforts will have to give and take.

So, what have we said? We've tried to outline some concerns in reference to collaborative roles. One is, let's not let the term become more important than what we are trying to do. Another is that we got to make dollar sense, talk about real savings, we've got to talk on a projected basis as to what we estimate things will cost. We've got to at least build this into our thinking about any program. It simply is not enough to make a shift that theoretically is a good shift. The consumer is not going to buy it. I think within our collaborative activities we have to identify where the action is--we've got to clarify our objectives--have them spelled out so that we can evaluate down-the-road community change, health status change. Not change that makes us feel good about our own facility or organization or professional group. Changes that are real out there where the people that are buying our services are. Further, I think we should avoid the idea that we do not have to sell what it is we've got when we know what we've got is good.

Again, I think we run the risk of tripping over our own specialization.

And, lastly, I think we have to face the gut issue that there has to be some organizational mechanism that can facilitate major trade-offs between groups like those represented here today before we can make collaborative efforts work.

Dr. Margaret Bogan: Summation

During the past two days I have heard considerable discussion about the need for cooperation between educators and people in health occupations. Apparently this kind of cooperation has not been evident in the past - otherwise it would not have been selected as the theme of this conference. I must take your word for events of the past, for I am new in this area and came to learn.

If Representative Barr's statement that education and health care are destined to be the two issues receiving the greatest amount of attention nationally, then I suspect we had best put our individual houses in order and work together. It appears that we have some common problem areas, and many of the issues with which health planners are grappling, now, have been issues in education also. One example has been the attempt to analyze the teaching act and to create "career ladders" much as you have been talking about in the field of health care. Educators have not been outstandingly successful in this endeavor - perhaps you can learn from our mistakes.

As an educator, I have a particular interest in curriculum and would like to comment on some of the curricular implications arising from the conference discussions.

There is no doubt that new roles have been defined for health personnel. This has been legislated. The question now is - are we as educators prepared to train health personnel to perform the new functions designed for them? Will we be willing to make appropriate "trade-offs" in curriculum to accommodate new priorities? As an example, will educators be willing to develop criteria and procedures for evaluating experience rather than developing more "courses"? Again, if teaching each person to be knowledgeable and proficient in administering a certain amount of self-health-care is a high priority item, what are we willing to "trade" to make time, money, and personnel available to meet this need? Is the idea of deleting one or more of our traditional requirements to accommodate a new concept too disturbing for educators?

It may be.

In the discussions, I think we also talked around an issue that is really crucial to the success or failure of any change in the status of people or programs. Can we change the attitudes of both professionals and laymen toward the traditional roles played by physicians and nurses? If we agree that we can and should do this, then we have a vital education problem to solve.

As usually happens at conferences, we tended to evade the real issue - what is the best health-care delivery system and how can we provide it? - and become somewhat protective toward our own systems. But, in spite of this, I feel the conference has been productive. If nothing else, we know each other a little better and will, hopefully, communicate more effectively in the future.

Dr. William E. Smith: Summation

Now that I listened to my charge, Margaret, and in the hopes that I won't be just a larger addition of the same report, I'd like to talk to a point because you who are here today represent the worlds of the people that comprise the best of my past experiences. I've spent a great many years in education; I've been with the hospital association and connected with health occupations in the last three. Now that's very difficult, still being 29. But, I'd like to just talk about some of the things I heard. I think we began with Dr. Melick, who challenged all the presenters via Dr. Hayakawa. A few accepted the challenge--most of them, I think, ignored it, but that's within the realm of each presenter. Dr. Prince, I thought, issued a great challenge to me and to our industry. He asked several questions concerning planning. Especially, he requested that we, as a conference, and as an industry and as an educational institution begin to formulate a blueprint that would outline a cooperative effort. I think, that from this charge, this conference could be a beginning. Most of the presenters spoke to the fragmentation, and to the high cost within the health field. It was interesting to me, as an educator, that the educators were criticizing the health field for fragmentation, lack of communication, high costs, public criticism, and need for change. If as many health administrators were to have a chance to stand up here, they would have equally criticized the education field. We have listened the last two days to a need and demand for a total systems approach -- new mechanism for financing not only the health system, but also the educational system. We talked about single systems of delivery, which, I think, are haunting both the educational field as well as the health field: the proprietary versus the non-profit and public, etc. It was extremely enlightening for those who attended both yesterday and today to listen to

the legislators' views of which we heard two divergent opinions. Much of our future does lie in these legislative areas.

I was most interested in Dr. Spector's question, "Why is the health industry different?" Well, I suppose that possibly the reason it was asked is that we are so much alike that our differences are thus more apparent to us. Because, you see, Dr. Spector, we are also a large industry, we are also defensive, and we are also accused of not seeing the big picture.

Now, some of the problems that we spoke of, which I think must be resolved are -- 1. Licensure and registration have been spoken to. I think what we need is to look at nationwide standards; we have to accomplish reciprocity, and we have to tear down the artificial barriers that exist, not only in the educational fields as far as licensure and certification, but also in the health fields. We have to come to the point where we must recognize, we must admit that the individual, to be fully utilized to the best of his abilities and competencies, depends upon us. The artificiality of some of our regulatory agencies and systems must be overcome. Distribution within the health field is possible to overcome by training great surpluses in the cities. However, one of the problems that we face in the health industry is that we are, in a sense, women-dominated, by sheer numbers. In fact, we have more women hospital administrators in this state than we have women superintendents. This is one of our tremendous distribution problems. In other words, the primary wage earner in a family is the male and since our health professionals are largely women, it is difficult to have them move to the rural areas. Problem #2 concerns the location of training programs, as has been discussed. We would like to see the educational institution bring and create training programs where our greatest needs lie. I don't think that we can just isolate and locate them in the major metropolitan cities. There are tremendous

needs in the rural areas. If the agricultural department for agricultural training can do it, it can be done for teacher training and I think we can also accomplish this for the health field. We have to make a study of our recruiting methods. Possibly what we have to do is to start concentrating and recruiting in those areas where our greatest needs lie. We should not only recruit in the major metropolitan areas but should hope that we can get people to go to rural areas from the metropolitan. We must investigate the recruiting methods that we are utilizing. This brings us to Problem Number 3: Some of the studies that we have possibly taken in this respect show that one difficulty we have is not one that was alluded to yesterday. The difficulty is the fact that the people think it's a second-rate position to be in the health care field if you're not the number one man--the doctor. The problem we found in our health careers program is that the youngsters do not know what opportunities exist in the health field. In a survey at Maricopa Tech, I occupied the sidewalks one day and talked to 50 youngsters. I asked them how many different opportunities and job opportunities there are in the health field. Most of those of the 50 that I asked, from 16 to 22 (and I didn't try to identify whether they were boys or girls; it's too difficult), could name about five jobs that exist in the health field. They said, doctor, nurse, and began from there; if they were innovative, they'd maybe say nurse, doctor, and they started from there. One person named as many as eight, and another person named as high as 13. To him I said, "What happened?" and the young fellow answered, "Well, I just spent three weeks in the hospital." I thought that was a very difficult manner of achieving occupational education. Another, and the only person who was able to name more than that, was a young lady and she could name 31 occupations. I said, "What's your story?" She responded, "Well, I'm a licensed practical nurse at St. Joseph's." In teaching, we recruit people for teaching for 12 years: "You know, very bright young man, you should be a teacher!" or, "you should be a football coach!"

I think that we have to study the recruiting methods now used in health fields. We have to look outside of the state for recruiting, also, to find where there are great surpluses and to attempt to attract people into the state and so that we don't all, in each state, establish our own training programs. We must serve the entire spectrum, as far as that goes.

Another major problem that exists between both the educational institutions and the health care fields is a lack of confidence in each other. The reason for this is a lack of knowledge and understanding of both our problems and of each other. I think a lot has been accomplished by the cross-over of people who have been in the health field and now the junior college level and secondary level. I think a lot of communications take place. The reason there may be this difficulty is that we are so similar. We have tremendous similarities. I would insist upon the fact that if Dr. Prince and Mr. Morris would exchange positions, and I'm not suggesting they should, and probably they wouldn't, I think that they could exchange positions. I think there is such a thing as public administration. I think we are moving in this respect. I think there is a tremendous need for articulation and cooperation. We've talked of this. I think it is being accomplished. I think we've made a lot of steps. I think the community colleges help tremendously in this area; I think vocational education, through health occupations, I would hope that the work that was started has begun would continue to operate on the same level of achievement. The manpower survey, the health career programs, all occupational programs that are being carried on are results of articulation. The present effort that is being made in northern Arizona, as far as planning of health education programs with the manpower needs and clinical facilities will have significance. I think there has been an increase in the number of agencies that cross over. All of this has been a help.

I would charge this! That I requested to be last in

order to allow my friends to leave before I begin to talk, and also, in order to make this charge: I would see that this is not the end of this conference, and it better darn well enough be a beginning. I suggest that right now the planning committee sit right down and get more input and a wider variety than at a later date; that they establish a council or some agency or something on a voluntary basis, so we can begin planning for next year. Therefore, when we arrive, we shall have position papers ready to be presented; we shall have had input before we get here; there will then be a greater delineation of objectives, and when we get here, we can begin to talk right from the very beginning.

And, I thank you.

GROUP SESSIONS

ISSUES

GROUP I

Responsibility of planning authorities (state and local)
re: manpower planning and training.

Need for licensure and certification of allied health personnel.

Need for faculty.

Continuing Education requirements for allied health personnel--
who should provide continuing education?

Health Education of the family.

GROUP II

Lack of communication between professional groups.

Planning
Industry must determine what it wants and really needs.

One of the problems we face is defining a mechanism for mutual planning between user and trainer.

Lack of selection standards for clinical experiences.

Periodic appraisals of manpower needs.

No mechanics for projecting manpower needs.

Organizing consuming public to help influence changes in existing health delivery system.

Need for joint planning.

GROUP III

Necessity for an accurate data base on needs for allied health manpower. Funding for health information center. It must be on-going.

A critical need exists to provide clear channels of communication among and between concerned agencies, institutions and individuals.

The decision-making body (Planning Authority) must be provided the means (authority and money) to be effective.

There needs to be a greater emphasis on preventive medicine (community health programs, school health programs).

GROUP IV

Need for coordination of planning efforts
(Improve articulation and amalgamation between training programs and service agencies.)

Need for control on statewide basis.

Need for statewide identification and clarification of titles and functions of all health workers, including aides thru physicians.

Need for protection of the consumer of health services
a.)functions
b.) levels of competence

Need for training and educational programs designed and prepared to meet health care needs.

Need for health care to all persons, e.g. rural areas--
need for primary care worker in all rural areas.
How do you handle the social and professional isolation?
Would "rotation" system like Canada's work?

Need to prepare minority members for health field. Need to revise educational system to facilitate the success of minority members.

Need for monetary accountability.

Statewide plan include career ladder. (Put pressure on University to look at its responsibility.)

Statewide involvement of health service agencies in identifying function of health worker.

Define performances in behavioral terms. Set up statewide computer-data bank for all health workers by levels e.g., aide, technicians, to be revised annually.

(continued)

Grcup IV (continued)

Need for involvement of physicians in total health care planning (even if it takes a directive from the Governor).

Set up continuation of this conference type of planning group.

a.) If concrete recommendations come out of conference.
b.) To work toward concerns.
c.) As the mechanism of pulling together <u>all</u> the planning being done.
d.) To communicate results of state plans and progress to <u>all</u> groups involved in State.

Need for authority to be given to implement coordination and control (from State legislature).

GROUP V

Health and Education need a better way of getting together and communicating. A cross section of the health field is needed. Medical doctors and dentists need to be represented.

Physicians' Assistants. Areas to be studied: Need, Job Description, and Utilization.

Do we need more nurses?
Where do new graduates go to work?
How do you determine the number of programs?
Where are they needed?

Often medical problems are related to culture. This type of help has not been defined.

Rural areas do not have professional help.
What about neighborhood health care?
How do we get R.N.s into the rural community?

Education is faced with problem of determining what level to train. Where are the clinical resources?

Look at the whole management concept--why the manpower turnover in hospitals?

Many hospitals are over-loaded with students in health careers, particularly nursing.
Arizona Radiologic Technology Programs have difficulty placing students. Some out-of-state schools are being accepted by Arizona hospitals.

Is there a tremendous need for health occupations? Are there areas that we are over-training? Seems to be confusion as to type of programs we do need.
Seems like we're talking about a need to coordinate a plan. Do we really know what we need? We need to do something at a state level.
Do we need state control of training programs? i.e., Dental Hygienist, R.N., Physician Assistant, etc.

GROUP VI

Data System--People, Needs, Services, Emergency.

Placement Incentive--Federal, State, Local.

Cost of Health Occupations Programs.
Finance--how? who?

Types of Educational Programs -
Agency responsible for training
Intern
Schooling
Human Relations

How does Technology fit into Health Careers -
who does the teaching?
how identify manpower shortage?
how much technology should be involved?

Need to coordinate various Health Occupations programs throughout the state.

Need for Social Economic Aged Programs -
Sun City and Florence.

How do you get people to become involved in health programs--to actively participate on voluntary basis?

Will these health programs lead to Socialized Medicine?

What is Socialized Medicine?

Will the mix of responsibilities interfere with total well-being of people being served--Dentist--M.D.--Social Worker--Family Health Worker--Nurse--Home Nurse Care.

(continued)

Group VI (continued)

Where in the M.D. training curriculum will he be oriented to the fact that needs, today, require the M.D.'s utilization of assistants to provide adequate health services? It is coming (comprehensive health care) but where do we begin?

What is the role of the State agencies in organizing the direction to take?--State, Medical, Nursing, Central, Hospital Administration, etc.

Who will determine level of training or competence needed for specific jobs?

Where do accrediting bodies fit into the scheme of things?

To what degree should those not trained in the health care field be involved in the decision making process for the training of those who enter the health care field?

GROUP VII

Determine need.
Strong support for data base

Plan to satisfy the need.
Designated training agencies in cooperation with clinical facilities.

Development of coordinating agency to work with training institutions and agencies served.

Statewide plan to include:
a.) employment opportunities thru manpower studies
b.) data bank established
c.) cost analysis
d.) faculty education programs

Data Bank (State Center for Health Information)
In addition to surveys of employees we recommend discussion of a data base on:

a.) approved programs
b.) projected graduates - balance
c.) projects for manpower development program
d.) cost analysis
e.) mobility of health workers

Job Registry and Centralized Placement Bureau for manpower.

GROUP VIII

We can plan and talk about comprehensive health care services to rural areas. In the final analysis however, the question of "who will pay for these services" will loom as being paramount.

Guidelines defining parameters within which physicians's assistants will operate must be established. Conversely, professional and legal responsibilities of supervising physicians will need to be clearly defined.

There appears to be a question regarding practicability and effectiveness of video-tape, telephone, and computers as used by assistants and physicians in the health care process.

The Career Ladder (utilizing the core concept) must be implemented for more effective training of health care personnel on all levels. University resistance to accept transfer and the problem of funding will remain as stumbling blocks to this concept. The physician's assistant must be built into this educational concept.

Physician's assistant: are we really creating a new position? Nurses now function very closely to a level that would be occupied by an assistant. Perhaps nurses (with a bit more training) could function as physician's assistants. There is, however, resistance to this concept by nurses. They feel that they already function at high levels of responsibility. We should not encourage nurses to pursue physician's assistant roles, thereby further depleting an already small "pool" of nurses.

Several educational agencies are providing various levels of training of health personnel. In some instances, there is a duplication of effort. In many instances, there is competition for use of clinical facilities. Coordination of effort is needed. Back to the "ladder concept?"

We need to study utilization of the various health workers we now have. Perhaps a re-definition of roles is necessary.

RECOMMENDATION: Physicians must be involved at future conferences of this type. Assign physicians to certain key roles in conference planning and actual conference program. Asking them to actively participate will encourage them to attend.

GROUP X

Geographical Areas to be served.

Filling void left by current trend to lessening training in specific areas. Courses being dropped by hospitals.

Lack of communication between industry, education and professions.

Maldistribution of trained supportive personnel, e.g. Medical Records Librarians.

Competition is extremely keen--40 podiatrists in Maricopa County, but cannot get into hospitals.

Malpractice--Physicians alarmed over costs. Legal barriers to physicians or other paramedical people providing services.

Transient population.

Institutionalized medicine will cost more.

Paramedics - screening process.

Identify those paramedical services that state has a need for versus those that are not necessarily needed.

Are there enough public clinical services available to emergencies and chronically ill persons?

Need for allied health personnel varies by areas.

Make sure there is adequate and accurate data for use in preparing plans.

Should we have full time persons gathering data versus one time-one shot collection of data each year?

Are we hearing realistic identification of needs--of solutions?

(continued)

Group X (continued)

Should "incentive" plans be used in allied health field as well as in "M.D." training?

Mobility of female in health field probably not as much as male. Work where husband is located.

Women move into and out of field of health service. E.g. childbearing--mov[illegible] etc.

Built-in barriers of overspecialization and legal barriers prevent economical health care delivery.

Differentiate between health-care information and health education.

Sources of funding.

Who should do the training?

Needs for allied health training areas change rapidly.

Are core programs in the institution the way to go with clinical experiences in the hospitals?

Poor or inadequate planning.

Lack of mobility from Armed Services into civilian fields.

GROUP SESSIONS

RECOMMENDATIONS

ISSUE I

Need a mechanism for mutual planning, coordination and articulation between the health industry and education for preparation of health manpower.

Group No. 1

Recommend State Planning Authority in collaboration with Local Health Planning Councils and all appropriate governmental and voluntary organizations be the mechanism for mutual planning, coordination and articulation between the health industry and education for preparation of health manpower.

Group No. 2

We recommend that the Comprehensive Health Planning Councils serve as the planning, coordinating and articulating body between the health industry and education to provide for a comprehensive program of health manpower preparation.

Time line--now.

Continue to call groups such as this together to identify and resolve issues.

ISSUE II

Is there a need for a central authority for health manpower planning and implementation? (Would include the preparation, utilization and upgrading of health workers.)

State control?
Standardization?

Group No. 8

Use existing authorities and agencies in a collaborative effort. We do not feel that creation of an additional agency is necessary. Arizona Health Planning Authority should be the central authority. This group should not have control, but should be a policy/recommendations group. The group functions as a "coordinating agency."

Standardization is already with us through the various agencies. Guidelines and criteria which could be used as a base to give programs direction should be established by the Arizona Health Planning Authority with input from all other agencies.

Group No. 9

There is a need for central authority for health manpower planning and implementation.

Suggestions: State Health Planning Authority
Coordinating State Committee

Need legislation to establish authority.

Thru federal, state, and local funding.

Should be established within next legislature.

ISSUE III

Need for health information center (data bank).

Projected manpower needs
Program capabilities and performance
Retrieval system

Group No. 6

Arrive at a series of indicators of the general health of the people.

Clearinghouse (Data Bank)
Information available and known of its availability - linked to user
1.) Implementing Agencies
a.) State Health Planning Authority and Health Department in conjunction with the State educational system.
b.) Regional Medical Program
2.) Time Line - Immediate and on-going.

Group No. 5

There is a definite need for a health services information system in Arizona that should (1) project manpower needs as well as current market demand, (2) aid in the definition of program capabilities and performance, and (3) that the information be utilized with respect to definite programs.

ISSUE IV

1. Need for statewide identification and clarification of roles and functions of all health workers in behavioral terms.

2. When above health workers are defined, will certification or licensure be the method of control?

Group No. 3

1. There is a need for national completion of the identification of roles and areas of responsibility with adaptation at the state level being the joint responsibility of professional groups, consumers, and facilities utilizing these personnel.

2. The same as identified in No. 1

Further Recommendations:

Critical need for evaluation of performance, therefore, above committee could set standards of performance (behavioral terms) for initial "licensure" and facility employing personnel could recommend for re-certification or re-licensure.
Do we really need licensing? Is it primarily for protection of the public or prestige for the worker (salary, etc.)?

Group No. 7

Recommendation that Regional Medical Program request, now, a Federal Grant to be used to establish a cooperative study to be conducted by a representative statewide Allied Health Manpower Standards Committee to determine the roles and functions of allied health workers in behavioral terms.

ISSUE V

Need for provisions for mobility within, and between, health specialties and occupations in preparation and in in-service education programs.

Group No. 4

Recommendations:

I. Appoint a joint committee to study and identify functions and levels at each level of health worker--assistant, technical, baccalaureate, etc.

A.) Develop committee with representation from

1.) health service agencies
2.) Department of Education
3.) accrediting, licensing and regulatory agencies.

B.) Define knowledges, skills, attitudes required for each function and level of health worker.
C.) Set up a system of evaluation of knowledges, skills and attitudes.
D.) Determine a method to enhance mobility.
E.) Study applicability of UCLA project data to Arizona.

II. Committee to make recommendations to State Department of Education.

III. State Department of Education to move on committees recommendations.

IV. One Year for Committee

V. Financing

A.) State Department (Committees)
B.) Go for funding like UCLA

Concerns:

I. If voluntary, what can you expect?

II. Cannot expect persons to work on committees if holding down full time jobs.

(continued)

ISSUE V (continued)

Need for provisions for mobility within, and between, health specialties and occupations in preparation and in in-service education programs.

Group No. 10

Recommendations:

I. We recommend increased funding for continuing education for servicing programs to be provided to a number of health specialties and occupations at the same time.

A.) We recommend the Arizona Comprehensive Health Planning Authority and affiliates be involved with the development and/or implementation of the recommendations.

B.) We recommend the implementation date for this recommendation be January 1, 1973, or as soon as possible.

II. We recommend there be established a method of coordination between various licensing and accrediting groups.

A.) We recommend the Arizona Comprehensive Health Planning Authority and affiliates be involved with the development and/or implementation of the recommendation.

B.) We recommend the implementation date for this recommendation be January 1, 1973, or as soon as possible.

III. We recommend that a study be conducted on needed legislation on both the national and state levels.

A.) We recommend the American Hospital Association and affiliates be involved with the development and/or implementation of the recommendation.

B.) We recommend the implementation date for this recommendation be January 1, 1973, or as soon as possible.

CONFERENCE EVALUATION

COMMENTS FROM PARTICIPANTS

1. What were your expectations for this conference?

That some mechanism be developed or at least some ideas generated to start communication between the health industry and education for planning for preparation of health manpower.

Become acquainted with health occupations.

Better understand common areas of concern and problems mutual to education and the health industry.

Discussions of problems of health manpower.

An interchange of ideas on how to improve the quality of the health delivery system, maintain or reduce costs (if possible) and, most important, provide the same level of care to all persons, particularly to those in rural/remote areas.

Communication between education, hospitals, health groups.

Expected to obtain an overview of problems relating to education of health workers and those relating to the consumer.

Uncertain what to expect.

To hear what other people in the State feel are the issues, needs, and directions for health occupations education.

Broaden my exposure to differing viewpoints of the crucial areas within collaborative venture between as many as possible elements important to health care delivery.

Somewhat of a launching pad to a reawakening of concern for the needs and fulfillment of those needs in the area of supportive aids and personnel in the health fields.

To make people aware of some of the problems in education and manpower in the health fields. Hopefully initiate lines of communication for collaboration in the different careers or professions.

Primarily for further communication and dialogue with others in health field--to engage (or begin to) in cooperative planning to meet needs of various Arizona communities.

To have a broader knowledge of the trends in health care for Arizona, and to begin to better define for myself and my profession (social work) where social services can best serve toward the total goal. Social work is in the process of a national assessment regarding both B.A. and Masters level curriculum regarding health services input, and I hoped that a conference like this would serve to clarify my own thinking about this.

(continued)

1. What were your expectations for this conference? (continued)

Definite action to implement a program for health services delivery to all citizens of Arizona by voluntary organization of interested persons who could use data already available. There is enough expertise to begin now to provide models and trials in selected areas. Education and service must be partners and consumers are ready.

To gain some knowledge of proposed and on-going health-related career education in Arizona and how and where such programs are available. Also, hopefully to contribute in some way my own feelings about such education as it relates to my own professional organization and to share the past experiences of the association toward setting guidelines for the future.

2. Did the conference fulfill your expectations? (Please elaborate on your yes or no answer.)

At least the two industries heard about the problems involved in the other field. Not all speakers stuck with the subject matter.

More emphasis on rural health delivery system.

I knew so little to begin with that I had to learn from the Conference. Conference was well-planned in terms of presenting variety of views from both health and education people.

As a valuable and necessary first step. More discussions in the future.

The conference has been excellent. It has been informative, provocative and has certainly demonstrated that it was needed and timely.

Objectives not clearly understood.

Was delighted to hear Burton Barr, Dr. Prince express their views, concerns, recommendations. Was glad to hear the others, as it re-emphasizes the fact that the revolution (as Dr. Spector put it) in health care is affecting health occupations education.

In that it sought out questions rather than answers. I believe the "area of answers" or approaches to solutions would be a good base for a second conference.

I personally feel much more informed (although there is much more to discover) about the situations that exist in Arizona.

I was very much impressed with the concern "to do" something by everyone. It was most meaningful to meet other professionals and realize that all seem concerned about "planned" change. The interchange of information and ideas was most helpful to me.

I thought the general format was very conducive to bringing out the issues and getting us to constructively focus on the problems at hand--both in the general health care field and for our own professions.

(continued)

2. Did the conference fulfill your expectations? (Please elaborate on your yes or no answer.) (continued)

I got weary of Pima and Maricopa County and their problems and egos--it's not how the crow flies from Phoenix to Tucson or vice versa, but whether he makes pit stops in 14 other counties or craps on them as he flies over. Let big brothers get together and then provide us country cousins with some fuel, ammunition, and folks to get on with our business.

Not completely--I felt there was a great abundance or re-hashing what has already been done and what would be done "IF". I feel I did learn some things I was not already aware of, but there was so much emphasis placed on physicians, nurses, and physicians' assistants, that other health professions were largely ignored.

3. What was most constructive in this conference?

Dr. Prince's recommendations to take constructive action, following up on conference.

The overall emphasis on the fact that the citizen--rural or urban--has a right to sound health care.

Report of the "The Plan" as it stands today and where it is going.

Legislative concerns and how they are being met.

Getting the different points of view--legislators, educators, planners, etc.

Proposed goals of Allied Health Manpower Planning Council--of training and services to all people. Hopefully with the passing of necessary backing legislation.

Meeting and talking with educators.

The head-off statements followed by the buzz sessions.

The inter-agency interplay focused on the subject of health manpower.

The exchange of ideas provided potential solutions.

Workshops required to come up with specific recommendations.

Small group sessions.

The combination of excellent lecture presentations along with group discussion was good. I also would thank the planning committee for the selection of such a beautiful site for our deliberations. Carefree is a marvelous place to really "get away from it all" and concentrate on the purpose of a conference.

Variety of presentations. Words of warning from Legislators to get with it or take the consequences. Nursing showed state wide interest and enthusiasm and we are about our business of making changes and improving, expanding and extending our roles. Very good mix of interested parties. Consumers should be added.

4. Was any subject matter omitted which you feel should have been included? (Please list subjects.)

No--felt we had all we could handle.

Perhaps some more specifics about where we are now.

Overlooked was the impact of the breakthroughs in medicine and surgery on health care cost and education. The establishment of the Arizona Heart Institute in Phoenix will have a "pebble in the lake" influence on health care throughout Arizona.

Health related professions and their roles in the total health plan for Arizona.

Grass roots planning.

How to uncover the true manpower needs in the state. It is felt that needs exist where there is not an awareness of the needs.

Lacked manpower programs input.

Lacked representations from the various minority manpower to this planning body.

Lack of an informational system to hard-core manpower programs.

I'm still not sure that I understand clearly the role that education feels they should play in preparing health manpower--not health industry.

Certification/Licensure.

Continuing education.

Emergency medical services and the problems of malpractice as they influence the overall health care system.

Program curriculum.

How to fit allied health personnel into geographical area of need.

I consider "Health Education" and "Health Educators" to be a unique part of the total industry. Health Education a process and health educators as the catalysts in effecting behavioral change. It seemed to me that some participants used the term "Health Education" to indicate that type of education by which personnel are prepared, i.e., at 3:00 P.M. on the program - Thursday:

(continued)

4. Was any subject matter omitted which you feel should have been included? (Please list subjects.) (continued)

"How should the Health Industry and Health Education Plan Together, etc.,--"
I see this as relevant but not in the context as generally interpreted.

For the first in what I hope can be series of such conferences, I think a great deal of good subject matter was covered. I did have the feeling that many participants would like to have known more about some of the emerging new systems and concepts in health care and possibly these could be considered for other such meetings. These other areas could be things like (1) the different forms of HMOs now operating nationally and in Arizona--including the general conceptual framework for an HMO, (2) the concept of continuum of care which places the hospital as one link in a series of other types of health care--and the need for development of much more extensive use of other levels of care such as the Extended Care Facility, skilled nursing nurse, Intermediate Care Facility, licensed boarding home, and Home Health Services. Manpower training, needs, and applications of professional services of course vary with all these levels of care, and we need to think about getting people ready to fill these slots, and (3) present legal aspects of the existing national health insurance programs (both Title XVIII and Title XIX of the Social Security Act)--where they affect us today, and where they are likely to take us in five years or so.

More talk than doing at first session of groups. This was necessary, but the next meeting should be within 90 days and divide interest groups--

X = Big county population
Y = Small county population

Bargain)
Swap)--focus on delivery
Trade) level 1
level 2
level 3
level 4

5. Any further recommendations?

Creation of linkages with existing minority manpower programs.

Introduction of the Allied Health Manpower Plan to the CAMPS Committee (Comprehensive Area Manpower Planning).

The summaries from group sessions should have been discussed at the general session--perhaps more time should have been allowed for this discussion and some refined recommendations should have come from the total group.

Need minority representation.

Would like to have had the opportunity to meet other conferees.

Include more professional associations in planning and sponsoring future conferences.

Need to follow-up on recommendations of the conference.

Convene such conferences on a quarterly or semi-annual basis with specific studies recommended or assigned to groups/ formal organizations with the objectives of returning reports to the overall body at subsequent conferences.

Agree with Dr. Prince's closing recommendation.

The consumer was conspicuous by his absence in this conference--perhaps more people involved at the grass roots level could have offered much toward the coordination of efforts at all levels.

I hate to see another organization, but this seems necessary at this time. Student participation as well as consumers.

Simply that the action be continued. It was a great conference with much participation. Keep it alive.

This is a good beginning. It is hoped that future conferences will bring forth needs and their solutions strong enough to overcome legislative opposition.

That this be only the beginning of communications that really will result in collaborative planning among the health careers and eventually concrete results.

Thought it was one of the most worthwhile sessions I've attended in many long months. Well done. Would like to continue to be a part of this--for I see a role for the Health Education component in every aspect of the "Plan".

(continued)

5. Any further recommendations? (continued)

Enjoyed the conference very much and feel that it will have some impact on the problems we are dealing with. I hope it can be the first of many.

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